

THE IOWA ALLIANCE OF COMMUNITY MENTAL HEALTH CENTERS
RECOMMENDATIONS TO THE MENTAL HEALTH AND DISABILITY SERVICES STUDY COMMITTEE
CONCERNING PROPOSED 2012 LEGISLATION
November 30, 2011

ABOUT THIS COMMENTARY #2

The Iowa Alliance of Community Mental Health Centers (the Alliance), with 19 members, represents over half of such Centers accredited, or deemed to be, by the State of Iowa. They serve as the safety net provider for the majority of those with serious mental illnesses in our State. Alliance members (*see footnote*) primarily deliver child, adolescent, adult and family mental health services, and often substance abuse treatment, across most of Iowa's 99 counties that include two-thirds of the state's population.

This is the second in a series of Alliance commentaries addressing the general challenges and specific issues confronting Iowa's public policy makers as they undertake to redesign a major component of this state's public and private health care delivery systems. Commentary #2 is, in part, a response to the first two meetings of the Mental Health and Disability Services Study Committee [*referred to hereafter as "the study committee"*] on October 24 and November 17.

However, its main purpose is to suggest some specific topics the Alliance believes the study committee should include in the legislative products expected to flow out of that committee's deliberations when it meets December 19. The study committee is charged with producing and introducing a legislative bill by January.

The Alliance's Commentary #1, dated November 15, 2011, cited two chief challenges facing Redesign. The first is the short period of time available for making and implementing a number of important transitional policy decisions. The second is to find a way to blend currently diverse funding streams while at the same time balancing system cost drivers of eligibility, covered services, administrative expenses, and provider payment levels. The reader is encouraged to review these two documents together.

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Blackhawk Grundy CMHC, Waterloo
Southern Iowa MHC, Ottumwa
Richmond Center, Ames
Vera French MHC, Davenport
Berryhill Center for MH, Ft. Dodge
Midwest Iowa MHC, Iowa City
Plains Area MHC, LeMars
North Iowa MHC, Mason City
Abbe Center, Cedar Rapids
Poweshiek Co. MHC, Grinnell

MH Clinic of Tama County, Toledo
Northeast Iowa Behavioral Health, Decorah
EyerBall CMHC, Des Moines
Center Associates, Marshalltown
Seasons Center for CMHC, Spencer
West Iowa CMHC, Denison
Orchard Place/Child Guidance Center CMHC, Des Moines
Community Health Centers of Southern Iowa, Leon
Waubonsie MHC, Clarinda

SUMMARY OF COMMENTARY #2

The study committee should address the following subjects when drafting 2012 legislation:

#1 – Decide early in the legislative session whether or not to restore county levied property taxes to fund multi-county regions.

#2 – Legislate the specific division of functions between the regional entities and state government.

#3 – Define key provider roles and service expectations, especially those for Community Mental Health Centers and Federally Qualified Health Centers.

#4 – Mandate very specific subject matter tasks when defining the scope of the Workforce Development Group's report to the 2013 legislature.

#5 – Make decisions regarding Iowa's participation in the federal Affordable Care Act.

#6 – Weigh carefully the transition schedules for all elements of the system.

SUBJECTS FOR INCLUSION IN 2012 REDESIGN IMPLEMENTING LEGISLATION

In General

The recommendations that follow are in no order of priority nor do they represent a complete list. However, the Alliance believes all those listed should be acted upon during the 2012 legislative session. We recognize this will likely mean more than one legislative vehicle and will involve the subject matter jurisdiction of several legislative committees.

For example, issues of funding such as property tax levies by county governments necessarily involve the Ways and Means committees. Appropriations of state and federal program funding could involve budget sub-committees such as health and human services and justice system. Several standing committees including Human Resources, State Government, Judiciary, and Local Government could have jurisdiction over select subject matters.

Coordinating the work of even two or three committees will require a strong commitment by caucus leaders in both chambers. The Alliance hopes the process doesn't become fragmented and unmanageable. The transactional friction of the legislative process, which is always high anyway, can result in a paralyzing inertia to set in resulting in little substantive action being taken.

#1 – Decide early in the legislative session whether or not to restore county levied property taxes to fund multi-county regions.

The county levy authority for mental health costs was repealed last session. It was intended as a statement that the legislature is serious about mental health system reform. The

regionalization concept envisioned in SF 525 is dependent on restoring county authority to levy and pool property taxes. There is general agreement that the state cannot, or will not, assume those costs any time soon. If reauthorization of that levy in some meaningful form fails to win early legislative support, the regional concept is untenable. In other words, if that levy authority is re-instated early in the session, if even only as a transitional funding source, the regional concept remains viable for consideration of the policy choices enumerated below in Issue #2. To repeat, it is a threshold issue that must be addressed very early in the session before other elements of Redesign can be decided.

#2 – Legislate the specific division of functions between the regional entities and state government.

Several work groups included recommendations for numerous policy and administrative functions to be undertaken by these regional entities. The Alliance has serious concerns about the significant cost of these administrative duties. We believe the first step toward making those choices should be by undertaking a thorough fiscal note analysis of cost. The study committee and DHS expect counties and others to begin now to explore regional configurations. However, they cannot do their “due diligence” if the administrative costs and regional entity policy making authority are unknown. The Alliance Commentary #1 expressed serious reservations over the vagueness of these functional divisions puitlined in the work group recommendations. Perhaps the DHS fiscal report being delivered to the study committee on or before December 9 will allay this concern.

#3 – Define key provider roles and service expectations, especially those for Community Mental Health Centers and Federally Qualified Health Centers.

Last session’s major legislative re-write of Iowa Code Chapter 230A governing accreditation and governance of CMHCs should be re-affirmed. That reaffirmation should give serious consideration to action taken by the state of Missouri in October which designated its CMHCs as primary care health homes. We also reaffirm, however, our admonition in the Alliance’s Commentary #1 that the 2012 legislation mandating statewide core services not exceed the funding available to pay for them.

The FQHCs also have an important role to play. They have access to National Service Corp personnel, are designated as HPSAs, and receive significant federal funding. Giving both CMHCs and FQHCs priority provider status, with incentives to find mutually useful roles, will also incentivize them to develop new relationships with each other. This could be particularly important in addressing Issue #4 on workforce shortages. One Alliance member is already accredited as a CMHC and a FQHC. Several others have close working agreements.

#4 – Mandate very specific subject matter tasks when defining the scope of the Workforce Development Group’s report to the 2013 legislature.

Many commentators appearing before the study committee and the work groups warned of critical shortages in many areas of health care practice in Iowa. They all urged legislators to move quickly to find solutions. We agree with that assessment because our Centers must have qualified personnel to deliver services in both urban and rural settings. While the redesign

work groups asked that the legislation immediately create a Workforce Development Group, study committee members seem currently inclined to do so but give the Group a full year in which to come back with its recommendations.

Historically legislators have been reluctant to side with one group of providers over another. The Alliance believes that both the legislative and the executive branches must make these tough choices if the promise of Redesign is to be fulfilled. A good start in 2012 would be for key leaders to, at the very least, send a clear message to the health care provider community that, in the words of Representative Dave Heaton, “you either work it out yourselves [in 2012] or we will [in 2013].”

There are many good ideas for solving this chronic problem beyond just raising provider payment schedules. These include scope of practice enhancements for allied health practitioners, updating archaic statutory law and administrative rules to reflect advances in health care delivery, skill building and training within current scopes of practice for all licensed health providers, and domestic retention strategies for newly licensed post-secondary school graduates and currently practicing licensed health care providers.

An example of the latter would be to offer those critical skill licensees who have practiced in Iowa for five years or so to have 50% of the cost of their advanced training paid for by the state. Studies show that a professional person who stays in a community for eight years after graduation is very likely to continue their professional career indefinitely in that place. Paying for that next step of training is a good incentive for that professional to make that decision to remain in Iowa at a critical juncture in their professional life.

We also suggest that the University of Iowa Hospitals and Clinics has a unique opportunity and obligation to address the critical shortage of psychiatric services. Employing perhaps 25% of all the psychiatrists practicing in Iowa and the chief training facility for more, there must be ways using telemedicine, for example, to focus that collective skill to directly serve needy areas of our state.

#5 – Make decisions regarding Iowa’s participation in the federal Affordable Care Act.

Whatever the decisions are in this regard, most stakeholders agree that the governor and the legislature need to make them in 2012 even if a US Supreme Court decision next summer requires that those decisions be somehow revisited later in the year.

Major funding and policy commitments are involved and how and when they are made will impact a number of state health care programs including those related to MH/ID/DD. Potentially tens of thousands of Iowans will become eligible in 2014 for health care services under Medicaid and related programs alone. Cost shifting between state and county public programs and between public and private coverages is a serious concern. Making these ACA decisions could be one of the most serious political challenges to the future of mental health redesign.

#6 – Weigh carefully the transition schedules for all elements of the system.

To state the obvious, there are many moving parts in the children's and adult's, mental health, substance abuse, brain injury, and intellectual and developmental disabilities treatment systems. The legislature has decided to delay for one year the redesign of the children's and brain injury systems. There is a growing belief that the ID/DD system may also need to be transitioned over a longer period of time. This belief seems to be particularly strong among counties with significant commitments to this system. The Alliance believes this particular issue deserves very close scrutiny because of the unique and long-standing county-level relationships and the funding sources supporting it.

LOOKING FORWARD

This Commentary #2 is an effort to identify some specific areas we will be looking for the legislature to address as the statutory bill drafts emerge in the coming weeks. We sincerely believe that as the safety net provider for the majority of those with serious mental illnesses our Alliance has a good deal of expertise to offer in finding solutions.

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